Health Insurance Agents and Brokers in the Reformed Health Insurance Market

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Summary

Health insurance agents and brokers, collectively called "producers" by insurance companies, assist consumers and small employers in choosing and enrolling in health insurance products. Producers are licensed and regulated by the states. Traditionally, the federal government has had no role in regulating producer activities outside of federal programs such as Medicare Advantage. The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA), as amended, creates a limited federal role in developing standards for the use of producers in the health insurance exchanges, which are competitive regulated markets effective January 1, 2014. The additional regulation of producers and alternative health insurance information (e.g., the online insurance portal) and assistance services available to consumers may limit the traditional demand for producers' services.

PPACA also has a minimum medical loss ratio provision requiring plans to pay rebates to their members if a certain percentage of their premiums are not spent on medical costs. This provision may provide an incentive for health insurance companies to reduce their compensation to and/or utilization of producers as they seek to reduce their administrative costs in relation to their medical costs.

This report will be updated to reflect relevant legislative and regulatory activity.

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Introduction

In one survey, a large majority of consumers have reported that the health insurance market is very complex and that they required assistance in choosing a plan.[1] Health insurance agents and brokers, collectively called "producers" by insurance companies, assist consumers in choosing and enrolling into insurance products, generally sold in the individual and small group markets.[2] According to the Bureau of Labor Statistics, producers held about 434,800 jobs in 2008, with about 73% being independent, meaning that they are either self-employed or working for an independent agency or brokerage, and about 21% being "captive agents" that are direct employees of an insurance carrier.[3] The remainder work for banks and other companies within the financial services industry that have an insurance business segment.

Captive agents may also receive a salary, but all producers generally are paid sales commissions that are usually higher in the first year of a new sale, but continue to accrue each year the individual or family remains enrolled.[4] The commission is a percentage of the premiums paid by the enrollee or policyholder. No comprehensive independent data exist on the amount of health insurance commissions, but the available evidence suggests that initial sales commissions generally range between 3%-15% of premiums for the individual and small group markets sales.[5] Often producers receive a renewal commission if the plan member or individual policyholder stays with the insurer for plan years after the initial sale. Renewal commissions are usually less than the initial sales commission. Large group sales are often conducted by captive agents compensated with a combination of salary, commissions, and bonuses. Little is known about these costs in relation to premiums.

Approximately 24 million Americans are expected to enroll in individual and small group qualified health plans (QHPs) offered through the health insurance exchanges established by the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) as amended.[6] This could represent a new market for health insurance producers. However, their role in the exchanges is not guaranteed by law, and other information sources, such as the mandated consumer web portal,

[1] Assurant Health, "Agents and Individual Medical Insurance: Empowering Informed Choices, Enhancing Consumer Experiences," July 2009.

[2] The terms "individual insurance" or "individual market" mean health insurance coverage offered to individuals (and potentially their dependents) that is not in connection with a group health plan (§2791(e) of the Public Health Service Act). The term "small group market" refers to the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year (§2791(e)of the Public Health Service Act). These are the terms as amended by PPACA. Previously, a small employer had been defined as at least 2 but not more than 50 employees.

[3] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, 2010-11 Edition, Insurance Sales Agents, available at http://www.bls.gov/oco/ocos118.htm.

[4] Mark Hall, The Role of Independent Agents in the Success of Health Insurance Market Reforms," The Milbank Quarterly, vol. 78, no. 1, 2000.

[5] Leslie Jackson Conwell, "The Role of Health Insurance Brokers: Providing Small Employers with a Helping Hand," Center for Studying Health System Change Issue Brief no. 57, October 2002; Actuarial Research Corporation, "Study of the Administrative Costs and Actuarial Values of Small Health Plans," January 2003; Letter from Consumer Watchdog to Kevin McCarty, Chairman of the Professional Health Insurance Advisors (EX) Task Force, National Association of Insurance Commissioners, March 21, 2011.

[6] Congressional Budget Office March 20, 2010, letter to Speaker of the House Nancy Pelosi, available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

could provide alternatives to the traditional relationship between producers and health insurance consumers.[7] The exchange is to standardize information on insurance options and provide independent helpers for prospective enrollees called "navigators." One could argue therefore, that the exchange itself may reduce the demand for assistance from producers by making it easier to shop for different health insurance for individuals and small employers. Moreover, the minimum medical loss ratio (MLR) requirements of PPACA will place downward pressures on administrative expenses, including the use of insurance producers.[8] Thus, there will be an incentive for insurance companies to cut back on the use of producers or reduce their commissions in order to rein in their administrative expenses. Some observers, including associations of producers, have suggested that the regulatory and market changes resulting from PPACA could put producers out of business.[9]

This report provides a brief background on the federal and state roles in regulating insurance producers and the potential impact of the relevant PPACA provisions on the use of producers by health insurance companies.

Regulation Impacting Producers

State Regulation

With the exception of government sponsored insurance programs (e.g., Medicare Advantage) producer activity is generally regulated by the states.[10] States usually regulate producers by prohibiting unfair sales practices and requiring producers to meet standards to obtain licensure. Most states have adopted the National Association of Insurance Commissioners (NAIC) Model Unfair Trade Practices Act, or a similar statutory framework, which defines unfair methods of competition including misrepresentations and false statements regarding the benefits, false statements and entries about the consumer, failure to maintain marketing and performance records, failure to maintain complaint handling procedures, and misrepresentation in insurance applications for the purpose of obtaining fees or commissions.[11] With respect to licensure, states

[7] Section 1103(a) (as amended by 10102(b)) of PPACA requires that a web portal be established by July 1, 2010 to assist individuals and small businesses in identifying health insurance coverage options in each state. The new Office of Consumer Information and Insurance Oversight (OCIIO), in the Department of Health and Human Services, is responsible for implementing this provision. The website healthcare.gov was launched on July 1, 2010, and is expected to be updated with additional information in October 2010. For more information see http://www.hhs.gov/ociio/gatheringinfo/index.html.

[8] For more information on PPACA and private health insurance, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted), (name redacted), and (name redacted).

[9] Julian Pecquet, "Insurance Agents Fight for Survival in World After Health Reform," The Hill, August 22, 2010. Kate Pickert, "The First Victims of Health Care Reform," *Time Magazine*, August 26, 2010.

[10] Even in government sponsored programs such as Medicare Advantage the state role in regulating producers directly is generally maintained. In other words, federal regulators hold insurance companies accountable for the behavior of the producers they use rather than the producers themselves. For more information on Medicare oversight of producers see Centers for Medicare and Medicaid Services, "Chapter 3 – Medicare Marketing Guidelines For Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans, Prescription Drug Plans, and Section 1876 Cost Plans," June 2010, available at http://www.cms.gov/ManagedCareMarketing/Downloads/2011_MMG_060410.pdf.

[11] National Association of Insurance Commissioners, "White Paper on Regulation of Medicare Private Plans," September 2008.

have standardized their regulation through adoption of NAIC's Producer Licensing Model Act to create a system of reciprocity for producer licensing and uniform standards requiring that a producer be at least 18 years of age, pass a criminal background check, have pre- and post-licensure specialized training in the insurance product being sold, have a record of compliance with unfair methods of competition standards, and pass a test of knowledge regarding standards of practice for the producer.[12]

As part of their oversight of both health insurance companies and producers, states have developed complaint reporting systems that tend to be substantively similar, but may have some variation in procedure, such as the methods of submission (e.g., hardcopy paper versus online submission).[13] Generally, once a complaint is filed it is investigated by the state insurance regulator, and if the claim has merit actions are taken against the insurance company or producer, usually beginning with an order to resolve the matter that caused the complaint. Available data suggest that producer issues rank relatively low on the list of complaints that consumers make about their insurance coverage. NAIC's summary of reported complaints indicates that marketing and sales complaints (direct producer actions and their marketing management) ranged from 4.32% to 4.66% of total insurance complaints per year between 2007 and 2010, and only two specific subcategories of producer complaints (bolded) were ranked in the top 20 (see **Table 1**).

Table 1. Top 20 Reasons Why Closed Confirmed Consumer Insurance Complaints Were Reported, by Category and Subcategory, 2010

NAIC Code	Reason Category	Subcategory	% of Total
1025	Claim Handling	Delays	21.76%
1015	Claim Handling	Denial of Claim	15.05%
1005	Claim Handling	Unsatisfactory Settlement/Offer	13.10%
1035	Claim Handling	State Specific	5.79%
815	Underwriting	Cancellation	5.53%
805	Underwriting	Premium & Rating	4.69%
1120	Policy Holder Service	Premium Refund	4.11%
1105	Policy Holder Service	Premium Notice/Billing	3.01%
1125	Policy Holder Service	Coverage Question	2.91%
1115	Policy Holder Service	Delays/No Response	2.62%
816	Underwriting	Nonrenewal	2.32%
930	**Marketing & Sales**	**State Specific**	**2.23%**
1130	Policy Holder Service	State Specific	2.09%
829	Underwriting	Surcharge	2.07%
1001	Claim Handling	Adjuster Handling	1.57%
915	**Marketing & Sales**	**Misrepresentation**	**1.27%**
845	Underwriting	State Specific	0.75%

[12] National Association of Insurance Commissioners, "State Licensing Handbook," 2009.

[13] For more information on complaint submissions by state, see National Association of Insurance Commissioners, "File a Consumer Complaint," 2010, available at https://eapps.naic.org/cis/fileComplaintMap.do.

NAIC Code	Reason Category	Subcategory	% of Total
1007	Claim Handling	Medical Necessity	0.69%
1018	Claim Handling	Out-of-Network Benefits	0.57%
810	Underwriting	Refusal to Insure	0.57%

Source: National Association of Insurance Commissioners, "Reasons Why Closed Confirmed Consumer Complaints Were Reported," December 27, 2010.

Notes: Complaints are received across insurance product lines. The term "state specific" refers to miscellaneous subcategories of issues related to specific state regulations. A "confirmed complaint" is a complaint in which the state department of insurance has determined that the insurer or an agent of the insurer has committed a violation of applicable state law, federal requirements enforced by the state, and/or a term or condition of the insurance policy. Not all states participate in the NAIC complaints database.

State and Federal Roles Regulating Producers in the Exchanges

Sections 1311(b) and 1321(b) of PPACA require, that by 2014, each state establish a health insurance exchange to facilitate the purchase of qualified health plans (QHPs).[14] Essentially, the exchanges will be government-regulated marketplaces that, among other things, are to provide standardized comparisons between QHPs in accordance with rules established by the Secretary of Health and Human Services (HHS, hereafter referred to as the Secretary). QHPs are health plans that are certified as meeting a specified list of requirements related to marketing, choice of providers, covered benefits, value of coverage, and other features. [15]

PPACA establishes a federal role in developing standards for producer activity in the exchanges by requiring that the Secretary promulgate procedures under which a state *may* allow producers to enroll individuals and employers in QHPs and assist eligible individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an exchange.[16] PPACA also requires that the Secretary promulgate regulations establishing criteria for the certification of health plans as QHP. The certification criteria must include marketing requirements.[17] Thus, federal standards for the behavior of producers may be established by regulating how QHPs use them for marketing purposes. The states' traditional role in licensing producers is not changed by PPACA. A state may also establish additional rules for its exchange, but the state rules may not conflict with or prevent the application of regulations promulgated by the Secretary.[18]

PPACA also establishes the "navigators" program in the exchanges to assist individuals with enrollment.[19] Specifically, navigators are to conduct public education activities concerning QHPs, distribute fair and impartial information concerning enrollment and the availability of premium tax credits and cost sharing reductions, and facilitate enrollment into QHPs. Navigators may be licensed producers, but any individual or entity serving in this role must be independent of any

[14] If a state fails to meet the requirements for establishing an exchange then the HHS Secretary is required to operate the exchange in that state.

[15] For more information, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted), (name redacted), and (name redacted).

[16] §1312(e) of PPACA as amended by §10104(i)(2).

[17] §1311(c)(1) of PPACA.

[18] §1311(k) of PPACA.

[19] §1311(i) of PPACA.

health insurance issuer in connection with a QHP and must comply with standards developed by the Secretary, in collaboration with states, that ensure that information made available by the navigators is fair, accurate, and impartial.[20] Thus, if producers act as navigators they will not have their traditional role as being employed or directly compensated by health insurance companies.

Potential Impact of Minimum Medical Loss Ratio Requirements

While not a direct regulation of producer activity, the minimum medical loss ratio (MLR) standards established by PPACA will likely have an impact on the use of producers. The MLR refers to the percentage of premium revenues spent on medical claims. Thus, if a plan received $100 of premiums and spent $85 on medical claims its MLR would be 85%. Beginning no later than January 1, 2011, PPACA requires a health insurance issuer to provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the issuer on clinical claims and health quality costs, after accounting for several factors such as certain taxes and reinsurance, is less than 85% in the large group market and 80% in the small group and individual markets.[21] States are permitted to adjust the percentage for the individual market, but only if the Secretary determines that the health insurance market would otherwise be destabilized. HHS estimates that in 2011 between 2.8 million and 9 million members or policyholders will receive rebates between $587 million and $1.5 billion in aggregate.[22]

PPACA requires that, subject to certification by the Secretary, NAIC establish uniform definitions and methodologies for calculating the MLR. NAIC held a series of meetings and took public comments as part of its development work on the MLR, which was completed on October 27, 2010.[23] During this process, the National Association of Health Underwriters (NAHU), a professional association representing producers, argued that when commissions are paid as a percentage of premiums, insurers are merely passing the funding along and that this practice actually reduces operational costs by eliminating the need for mail and accounting for separate payments to producers.[24] In other words, the commissions portion of the premiums are not retained by the insurer and thus should be excluded from the calculation of the MLR. The consumer representatives of NAIC countered that Congress intended commissions to be counted as administrative costs for purposes of the MLR, citing §2718(a)(3) of the Public Health Service Act (as amended by PPACA), which clearly excludes federal and state taxes and licensing or

[20] §1311(i)(2)(B) and §1311(i)(4) of PPACA.

[21] §1001, as amended by §10101(f) of PPACA: §2718 PHSA. For more information, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted), (name redacted), and (name redacted).

[22] Member/policyholders were expressed in terms of "life years." Because the term of an insurance policy is usually one year, the number of covered lives is often expressed in terms of life years. Thus, one individual insured for 12 months equals one life year, and two individuals insured for 6 months each also equals one life year. For MLR impacts, see 75 FR 74907.

[23] Letter from the National Association of Insurance Commissioners to Secretary of Health and Human Services Kathleen Sebelius, October 27, 2010, available at http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

[24] Letter from Janet Trautwein, Executive Vice President and CEO of the National Association of Health Underwriters to the Department of Health and Human Services, May 14, 2010, available at http://www.nahu.org/legislative/mlr/NAHU%20Comments%20on%20MLR.pdf.

regulatory fees from the accounting of non-claims costs for MLR calculations, but does not specifically exclude commissions.[25]

NAIC ultimately concluded that the law does not provide a clear path for waiving inclusion of commissions in the calculation of the MLR, but it encouraged "HHS to recognize the essential role served by producers and accommodate producer compensation arrangements in any MLR regulation promulgated."[26] On December 1, 2010, the Secretary promulgated an interim final regulation for the MLR provision, effective January 1, 2011.[27] The Secretary concurred with NAIC's interpretation that the law requires that producer commissions be included in the MLR calculation. The Secretary also acknowledged NAIC's concerns about potential adverse impact of the MLR provision on producers noting that "the potential impact of the MLR standard on agents and brokers merits recognition, and in this regulation the impact of the MLR standard on agents and brokers will be a factor in considering whether a particular individual markets would be destabilized."[28]

Given that producer commissions generally rank only behind staff salaries among administrative expense categories for health insurers, it is likely that insurers at risk for issuing MLR rebates will cut back on their use and/or compensation of producers.[29] Indeed, preliminary evidence suggests that insurers are reducing their administrative expenses by cutting the compensation of producers.[30] The NAHU suggests that these cuts are negatively affecting access to health insurance agents and brokers, but they have not provided clear evidence of the impact on consumers.[31] This may be a difficult exercise given that no clear consensus standard for an appropriate amount of access exists.

It is also not clear how the MLR provision alone would seriously limit access when the provision merely provides an incentive to reduce administrative costs for some insurers. Many insurers will make the MLR minimum without significantly adjusting their administrative costs, and the insurers that must reduce their administrative costs could reduce expense categories other than producer commissions. Nevertheless, some industry observers have even suggested that cuts to

[25] Letter from Timothy Jost, Georgia Maheras, Stephen Finan, Joe Ditré, Sabrina Corlette, Brendan Bridgeland, Wendell Potter, Mark Schoeberl, Bonnie Burns, Elizabeth Abbott, Butch Hollowell, and Barbara Yondorf to Commissioner Sandy Praeger, October 8, 2010, available at http://www.naic.org/documents/committees_models_mlr_rebate_regulation_comments_1.pdf.

[26] Letter from the National Association of Insurance Commissioners to Secretary of Health and Human Services Kathleen Sebelius, October 13, 2010, available at http://www.naic.org/documents/committees_ex_grlc_mlr_sebelius_letter_101013.pdf.

[27] 75 FR 74864.

[28] 75 FR 74877.

[29] The actual total administrative cost of producers is higher because the commissions category on the accounting report does not include producers paid by salary or the administrative infrastructure managing the producers. National Association of Insurance Commissioners, "Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2008," 2009.

[30] Charles Boorady, Chris Carter, Jason Twizell, "Broker Channel Check, 2011 Key Reform Year," Credit Suisse, January 18, 2011; National Association of Insurance and Financial Advisors, "NAIFA survey of members who sell health coverage," April 25, 2011; Carl McDonald and James Naklicki, "eHealth Insurance: Bad Habits Are Like A Comfortable Bed. Easy To Get Into, But Hard To Get Out Of - 1Q11 EPS Analysis," Citi Investment Research & Analysis, April 26, 2011; Kate Nocera, "Reform law costs insurance brokers," Politico, January 6, 2011, available at http://www.politico.com/news/stories/0111/47128.html.

[31] National Association of Health Underwriters, "NAHU Supports Amendment to Defund Medical Loss Ratio Requirements," February 18, 2011, available at http://www.nahu.org/media/releases/2011/amendment409.pdf.

commissions are necessary and can be absorbed by producers. For example, Carl McDonald and James Naklicki, equities analysts at Citigroup Global Markets Inc., stated in a recent investor note that:

> plans have cut first year commissions in half, to around 10% of premiums, so brokers are still receiving a significant amount of compensation for the duties they are performing. Put a little differently, because most broker commissions are set as a percentage of premium, and because individual premiums go up so much each year, many brokers were generating twice as much revenue on a transaction in 2010 as they did in 2005. Now that first year commissions have been largely halved, it's logical to ask why a broker that was willing to be in the business at the level of compensation available five years ago wouldn't want to be in the business at that same level of compensation today. There's no doubt that the income of brokers has been reduced because of minimum MLRs, but brokers and agents benefited for many years from rising premium rates, and that trend isn't sustainable.[32]

The recent experiences of the Medicare Advantage (MA) and Medicare Part D programs also suggest that restraining producer compensation may not significantly affect access to services. For both programs the initial compensation for a sale is limited by regulations to the compensation paid in 2006, adjusted by the average change in MA or Part D rates as published by the Centers for Medicare and Medicaid Services (CMS); or a compensation amount commensurate with the market rate for initial enrollments paid by plan sponsors offering plans in the geographic area during 2006 and 2007, adjusted by the average change in rates.[33] The regulations further limit renewal compensation to no more than 50% of the initial compensation. Despite these relatively strict regulations, there is no evidence that Medicare beneficiaries are being systematically deprived of access to producers.

Another potential source of data regarding the impact of the MLR provision on producers is from state applications for an adjustment to the MLR standard for the individual market. Section 2718(b)(1)(A)(ii) of the Public Health Service Act (PHSA), as added by PPACA, grants the Secretary the authority to adjust the MLR standard downward in the individual market if the Secretary determines that the 80% minimum MLR standard may destabilize the individual market in a state. States may request that HHS revise the MLR standard downward, but they must provide evidence of potential market destabilization by demonstrating that:

- Insurance issuers are reasonably likely to leave the market and that they cover a substantive number of individuals.
- Absent an adjustment to the MLR standard, consumers would be unable to access agents and brokers.
- There are few or no alternate coverage options with similar benefits at a similar price available within the state for enrollees of issuers that are reasonably likely to exit the market.
- There will be a negative impact on premiums charged, the benefits offered, and the cost-sharing provided to consumers by issuers remaining in the market in the event one or more issuers were to withdraw from the market.

[32] Carl McDonald and James Naklicki, "Sometimes the Hardest Thing Is Knowing Which Bridge to Cross & the One to Burn: Analysis of Florida's Minimum MLR Waiver," Citigroup Global Markets Inc., March 16, 2011, p. 7.

[33] 42 CFR § 422.2274 for MA and § 423.2274 for Part D.

To date, only the territory of Guam and the following 10 states have applied for adjustments: Maine, New Hampshire, Nevada, Kentucky, Florida, Georgia, North Dakota, Iowa, Louisiana, and Kansas. Only Maine has fully completed the process and received authorization for an adjustment. However, the Maine application did "not discuss the impact of the 80 percent MLR individual market standard on access to agents and brokers."[34] The other applicants generally felt that the MLR provision would negatively affect access to producers. However, no empirical evidence was provided. For example, Kansas reported anecdotally that it had "heard testimony from Kansas agents and brokers that some Kansas issuers that currently use an agent model for the marketing of their products are making significant adjustments to their compensation models."[35] Given the lack of public data with respect to commission rates and the overall financial position of producers, it is not possible to independently assess the impact of the MLR provision nor is it possible to assess other potential sources of revenue for producers that may replace the reduced health insurance compensation (e.g., selling insurance products not subject to the MLR provision).

Legislative Activity in the 112th Congress

The Access to Professional Health Insurance Advisors Act of 2011 (H.R. 1206)

On March 17, 2011, Representative Mike Rogers introduced in the House the Access to Professional Health Insurance Advisors Act of 2011 (H.R. 1206). The bill would amend section 2718 of the PHSA to eliminate "remuneration paid for licensed independent insurance producers" from being counted as an administrative cost for the purposes of the MLR. The bill has been referred to the House Committee on Energy and Commerce.

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[34] Letter from Steve Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services to Mila Kofman, Maine Superintendent of Insurance, March 8, 2011.

[35] Letter from Sandy Praeger, Kansas Commission of Insurance to Secretary of Health and Human Services Kathleen Sebelius, April 29, 2011, available at http://cciio.cms.gov/programs/marketreforms/mlr/states/kansas/mlr_waiver_application_letter_04292011.pdf.